TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JUDITH ANN KNOWLES, DC

Respondent Name
UNION INSURANCE CO

MFDR Tracking Number
M4-18-0554-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 31, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS."

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill in question is for a service date of June 10, 2017. The provider billed for an examination on MMI in which she opined that the claimant had not reached MMI. She also conducted an examination concerning the claimant's ability to return to work. The bill was submitted…The provider billed a total of $1,350.00…reimbursed the provider $350.00 for the MMI exam and $125.00 for the ability to return to work exam…The carrier relies upon its EOR in support of its position that it does not owe any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2017	CPT Code 99456-W8-RE Return to Work Evaluation	$375.00	$375.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235, effective July 7, 2016, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
4. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement for 99456-W8-RE?

Findings

The issue in dispute is whether the requestor is due additional reimbursement of $375.00 for code 99456-W8-RE.

The respondent contends that additional reimbursement is not due because "The provider billed for an examination on MMI in which she opined that the claimant had not reached MMI. She also conducted an examination concerning the claimant's ability to return to work. The bill was submitted…The provider billed a total of $1,350.00…reimbursed the provider $350.00 for the MMI exam and $125.00 for the ability to return to work exam."

On the disputed date of service, the requestor billed CPT codes 99456-W5-NM and 99456-W8-RE.

The rule addressing reimbursement for code 99456-W5-NM is found in 28 Texas Administrative Code §134.250(2). The division finds the requestor was appropriately reimbursed for code 99456-W5-NM and is not in dispute.

The rule addressing reimbursement for code 99456-W8-RE is found in 28 Texas Administrative Code §134.235.

28 Texas Administrative Code §134.235 states "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

28 Texas Administrative Code §134.240(2) states "When multiple examinations under the same specific division order are performed concurrently under paragraph (1)(C) - (F) of this section:
(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in §134.235 of this title; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in §134.235 of this title; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in §134.235 of this title."

Since MMI examinations are exempt from the multiple examination reduction found in 28 Texas Administrative Code §134.240(2); the requestor is due full reimbursement for the return to work examination. Based upon the above rules, the appropriate reimbursement for the return to work examination is $500.00. The respondent paid $125.00. The requestor is due the difference of $375.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $375.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $375.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/13/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.